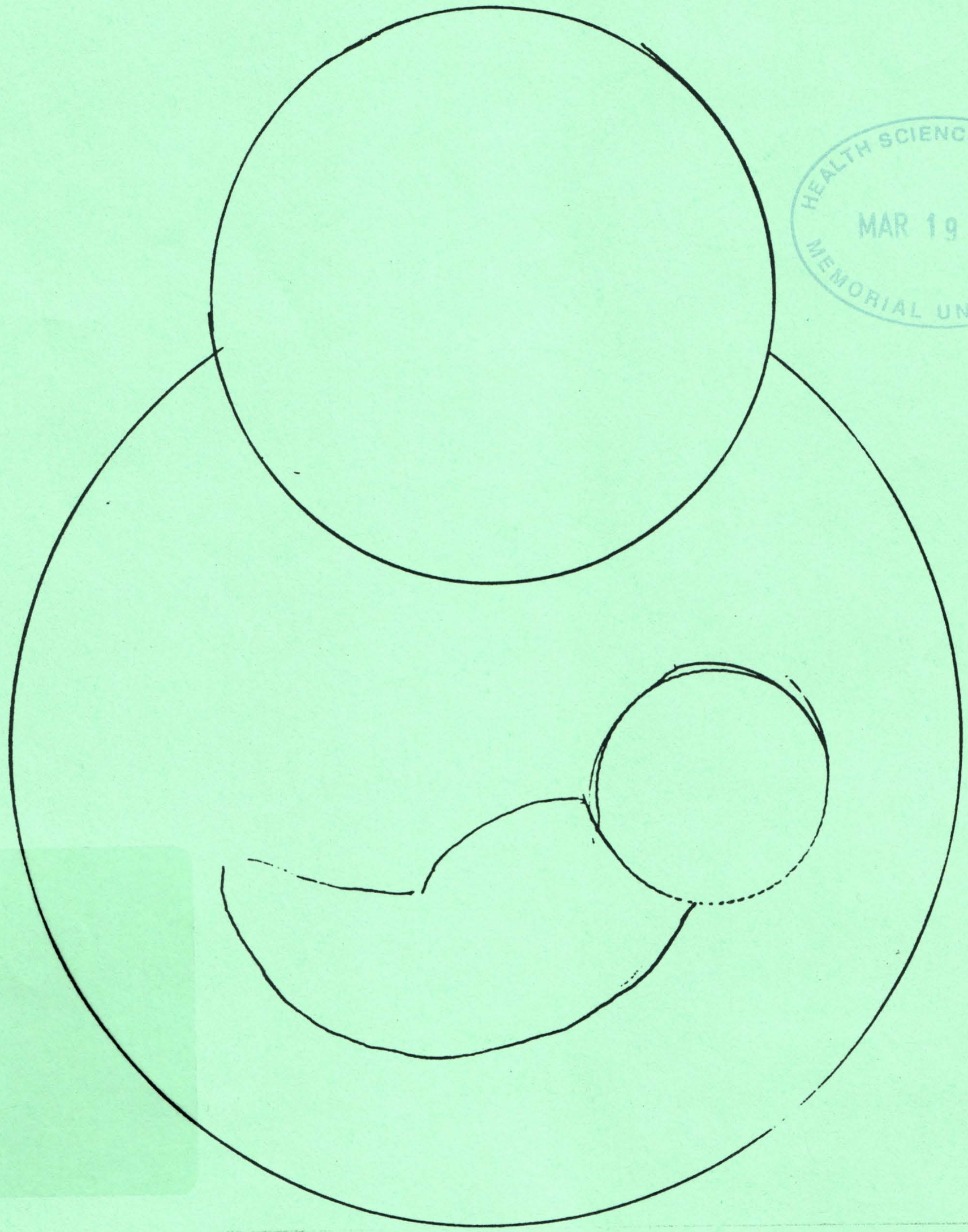
THE ALLIANCE OF MIDWIVES, MATERNITY AND NEONATAL NURSES OF NEWFOUNDLAND AND LABRADOR



Newsletter No. 18, January 1996

The Alliance of Midwives, Maternity and Neonatal Nurses of Newfoundland and Labrador

(A Special Interest Group of the ARNN)

Newsletter No. 18 (new issue) - January, 1996

I hope that you all had an enjoyable Christmas and that you will have a good 1996. There will be many changes this year but hopefully the care of mothers and babies will not suffer; any changes will be good ones.

There will be an important meeting on February 7, 1996, as the Alliance does need a president. Kay Matthews offered to cover for this position during the summer months, but since September we have been without a president. We must have the position filled. The treasurer needs someone to co-sign cheques so that our debts can be paid. (Banks require two signatures for association accounts).

On behalf of the members a gift was given to Karene Tweedie for her work on behalf of the Alliance. As was seen in the history of the Alliance, she became involved at the beginning of the 1980s as soon as she moved to St. John's and was secretary for many years. Condolence cards were sent to Flo Downey (NICU, SAGGH) and Kay Matthews (MUN School of Nursing).

Thank you to those who submitted items for this Newsletter. The editor is always willing to receive appropriate materials but the submitter accepts copyright responsibility for the item to be reproduced.

Membership fees are due for 1996. The application form is attached to the back of this Newsletter. As mentioned in the last Newsletter, there is an increase in fees for those outside of the country to cover postage costs.

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Alliance Meeting, Wednesday, February 7, 1996, 8 p.m. at 53 Rennies Mill Road, St. John's
Friends of Midwifery, Tuesday, February 13, 1996, 8 p.m. at 45 Whiteway Street, St. John's (Telephone: 579-4453)
Midwifery Conference, Friday, April 12, 1996, at Grace Maternity Hospital, Halifax. "Canadian Midwifery: The Growing Health Care Profession". (ANSM and CCM/CCSF)

Executive Members

President:	Secretary: Roma Quinton
Treasurer: Clare Bessell	Publicity: Janet Murphy-Goodridge
Librarian: Bernardine Moyles	Newsletter: Pearl Herbert

Summary of Meetings

The **Alliance Meeting** which was to be held in July was cancelled as there were too many people on vacation. There has been no other meeting.

Newfoundland and Labrador Midwives Association. A meeting was held in St. John's on November 13, 1995. The Midwives Association has lost members from the St. John's area as Sharon Ransom (who was the CCM/CCSF treasurer) has moved to Calgary; Karene Tweedie (who was the NLMA secretary) has gone to Glasgow, Scotland, to study for a masters degree in midwifery; Pauline has moved to Britain. Both Robyn Beaudry and Sandra LeFort are busy working on the research for their graduate degrees. Kay Matthews is still involved with the Safe Motherhood project in Nigeria. Karen Olsson and her family were in Norway for nine months and returned to St. John's in September. Maureen Laryea has returned to St. John's after obtaining a PhD degree at Ulster University.

Karen Olsson agreed to be the secretary. The lobbying activities were discussed. Pearl gave a report from the Canadian Confederation of Midwives/ Confederation Canadienne des Sage-Femmes (CCM/CCSF) November meeting of midwifery activities across the country. The CCM/CCSF is becoming recognized by various national committees. At present a nomination is being sought for the National Neonatal Resuscitation Program committee. The midwife has to be committed to attending all of the NRP meetings and to have the funding to be able to do this two or three times a year. (The next NRP meeting will probably be in Saskatchewan).

The 1996 midwifery conference will be held in Halifax, on April 12, followed the next day by the annual CCM/CCSF meeting. This conference is being arranged by the Association of Nova Scotia Midwives. Information can be obtained on e-mail from Charlene Maclellan (the CCM/CCSF representative for ANSM) rbent@acadiau.ca

The previous week the CCM/CCSF representatives had a telephone meeting and Pearl gave the midwifery reports from across Canada.

Midwifery in Canada, November 1995

British Columbia

In May 1993, legislation was announced for autonomous midwifery. On March 16, 1995, the Minister of Health announced the establishment of the College of Midwives of British Columbia and the appointment of a nine person Board. The College has struck committees to work on Standards of Care; Pre-registration; Public Relations; Complaints and Inquiry/Discipline; Quality Assurance and Education. The College is responsible for regulating and registering midwives. The Midwives Association (MABC) remains committed to quality care for childbearing women and providing professional and consumer education. The MABC has representation on College committees and an immediate priority is to represent midwives in matters of remuneration and benefits. The Ministry of Health's Midwifery Implementation Advisory Committee continues to provide advice to both the Ministry of Health and the College of Midwives regarding implementation strategies. It is hoped that implementation will be in 1996.

A coroner's inquest into the death of a 3 day old baby following a home birth attended by a lay midwife, who is not a member of the MABC, lasted from February to August 1995. The Coroner's findings and recommendations reinforce the MABC's

position on the necessity of having a regulated midwifery profession. The 9 recommendations were addressed: to the Ministry of the Attorney General (included to enforce as soon as possible the standards and regulations set forth by the College of Midwives); to the College of Midwives (included registration and licensure of all midwives should be an urgent priority; examine water births, home births); to the College of Physicians and Surgeons, the College of Midwives, and the RNABC (included establishment and implementation of continuing education programs to address issues surrounding the diagnosis and treatment of neonatal sepsis; attendance at these programs).

Alberta

Legislation for autonomous midwifery was passed in 1992. The portfolio requirements have been outlined and the sub-committee of the Midwifery Regulatory Advisory Committee (MRAC) is charged with the development of the process multi-faceted assessment. The initial application process has been completed and 94 applicants have been reviewed. Letters are being sent to the applicants along with the Portfolio which is an extensive review of the candidates educational and practice experience. The two external assessors are Mary Sharp (Ontario) and Marg Mansfield (Seattle). It is planned to hold the multi-faceted assessment in April-May 1996.

Alberta has taken part in some preliminary discussion on the possibility of a Western Region Educational Consortium. Talks are also on going with Advanced Education regarding negotiating with Ontario to obtain access to their materials.

Alberta has been decentralized into 16 Regions. Each Region is responsible for deciding what services are required. Downsized Acute Care Hospitals are now labelled "Community Centres". Home birth midwifery services can be negatively affected if a physician who is against them is in charge of planning the Regions community services. This needs to be solved prior to the implementation of midwifery as an insured service. Following licensure all midwives will be required to carry insurance.

The Alberta Association of Midwives (AAM) and the Alberta Association of Registered Nurses (AARN) Liaison Committee have been discussing ways that nurses can interface when midwifery is regulated in the province. A document has been prepared as a first step toward clarifying the roles and relationships between the two professional groups. It is hoped for implementation in 1996.

Saskatchewan

The Midwifery Advisory Committee to the Minister of Health (five midwives on this Committee) had to submit their report by the end of December 1995.

A number of the Midwifery Association of Saskatchewan members work as labour and delivery nurses. There are four practising midwives in the province and so the number of home births remains small.

Manitoba

In May, 1994, the Minister of Health announced that in Manitoba midwifery would become an independent, self-regulating profession. In November, 1994, members of the Midwifery Implementation Council (MIC) were appointed, under the direction of Dr. Carol Scurfield. The Association of Manitoba Midwives has representation on every committee, as also does the Manitoba Traditional Midwives Collective. The legislation draft will go to a legislative committee which writes it in the appropriate language in preparation for public hearings and the first reading in parliament in Spring 1996.

Midwives, educators and legislators from the three Western Provinces are meeting to discuss the feasibility of establishing a collaborative midwifery training program. The Education Committee is presently developing a "Core Competency Chart" which will be used to assess the skills of current midwives, to begin in the Fall 1996. It will also be used in the preparation of future midwives.

In November the Equity/Access committee is going to start visiting northern and rural areas. The Practice Committee is preparing Standards of Practice.

There is a Midwifery Project at the Health Sciences Centre in Winnipeg. The project is "headed" by the Clinical Nurse Specialist (CNS) who is also a midwife. The CNS and six staff midwives, in collaboration with an obstetrician, provide prenatal care to low risk pregnant women and care during labour, and carry out the delivery in the "low tech" Family Centred Care Unit, which is adjacent to the "high risk" labour unit. The CNS also provides care to pregnant teens at a local school.

The practising midwives of the Manitoba Traditional Midwives Collective continue to be busy with homebirths.

The organization "Friends of the Midwives" has been formed, and they hope to have chapters throughout the province. They will help with the lobbying for midwives.

The Winnipeg Fire Department has a S.A.F.E. Baby Program (Smoke Alarm for Every Baby). Starting in January the Fire Department hopes to give a smoke alarm to every baby who is born in Winnipeg. They have invited the Association of Manitoba Midwives to represent midwives in this Program.

Ontario

Autonomous midwifery was implemented as from January 1, 1994. "Midwife" is a protected title and midwives have to be licensed to practice. Those seeking registration apply for the Prior Learning Assessment (PLA) process. Autobiographical portfolios are examined (there are over 200 people on the waiting list). The candidate must provide satisfactory evidence of graduation from a recognized midwifery program or registration to practice midwifery in another jurisdiction. Attendance in at least 40 births as a "primary" midwife or at least 30 births as a "primary" midwife and at least 20 births as an assistant to the "primary" midwife. (A primary midwife assumes sole responsibility for the care of a woman in the intrapartum period. Is the first point of access to care for women

seeking care during pregnancy and who functions without the supervision of a member of another health care profession, making autonomous decisions with full responsibility for the care provided).

The midwifery undergraduate programs continue. All new midwifery students go to Sudbury for a weeks intensive orientation session. The third year students (who were the first intake) will begin a midwifery Clerkship in May 1996. The College of Midwives (CMO) has agreed that students in the Clerkship may be considered second midwives at a birth (and the insurers have concurred). This allows students to actually be in the role of primary caregiver and prepares them for work in the profession. This may also result in some practices being able to accommodate more mothers.

The Association of Ontario Midwives offered an Emergency Skills Workshop at the time of their June 1995 Annual General Meeting. The workshop consisted of an examination, scenarios, practice sites and individual feedback regarding skills. A certification process will likely be a part of this type of education in the future. An Emergency Skills Booklet was developed for midwife members and has also been made available to midwifery students. Several areas where support to midwives are needed have been identified; administration, system, professional issues. A needs assessment tool is being developed, with the LMCO, to identify other areas.

This past summer members of the Association of Ontario Midwives completed a Hospital Integration Survey. A summary will be published in the December issue of the Association's Journal. The Journal was first published in October 1995 and next year will be published three times - Spring, Fall, Winter.

Due to the continuing need to provide information to consumers, people interested in becoming midwives, other professionals, and the government, the Association of Ontario Midwives has developed a brochure.

The Conservative Party is now the main party in the provincial government. They have made it clear that reducing the deficit is a priority. In 1994 funding had been approved by the previous NDP provincial government for four freestanding birth centres. On September 30, 1995, the Minister announced that this funding would be cut. A Ministry spokesperson was quoted as stating that the Minister of Health felt it was not appropriate to invest in the new centres when many hospitals were beginning to move to cheaper, low technology-type deliveries favoured by the birthing centre model, and home birth were becoming more widespread as more midwives became available. Current research and past data gathered prior to funding and legislation of midwifery services in Ontario confirm midwifery care is cost effective. Also, given the demand for midwifery services (currently midwives are unable to accommodate half of all women who contact them) the addition of more midwives will mean both improved access to care for women and a further reduction in costs to the Ministry of Health. At the Association of Ontario Midwives Annual General Meeting the members passed a resolution in response to the Health Minister's announcement that

midwives would become employees of Community Health Centre. As an employee model has the ability to undermine the autonomy of midwifery practices including midwives' ability to choose their practice partners and provide care in the Ontario model of midwifery practice, it was resolved that members of the Association of Ontario Midwives strongly support the contract model as the best mechanism to fund midwifery.

Quebec

Les Sages-Femmes de Quebec is a new group which first started in 1993. Full members have to be "recognised as qualified to practise within the framework of a pilot project" (Bill 4). They have 29 members and have applied to be recognized as a company. (The members of the Alliance Quebecoise Sages-Femmes Practiciennes have joined them and dissolved the Alliance). The other midwives' group, Association des Sages-Femmes du Quebec (ASFQ), is registered as a professional association and the members have resisted dissolving their group. The ASFQ has many immigrant members who qualified as midwives in other countries but were unable to pass the Quebec examinations because of language difficulties. Midwives are not "licensed" so "midwife" is not a protected title because there is no licensing process. The future of midwives is unknown after the pilot projects across Quebec finish in September 1998.

Northwest Territories

In November 1993 the Rankin Inlet Low Risk Community Birthing Project commenced, to run for two year. However, given that approval for funding the evaluation from the National Health Research Development Project (NHRDP) within the Federal Government was not received until April 1, 1995, the project will be extended until March 31, 1996, so as to have one full year evaluated by an independent evaluator. In order to access funding for the project's continuance after March 31, 1996, the staff are looking at integrating the program into the Community Health Centre's current Maternal and Child Program by December, 1995. A working group of representation from the NWTMA, NWTRNA, and NWTCPHA, have been looking at "pending" midwifery issues.

In 1995 there was a general election in the NWT and the new Minister of Health and Social Services support low risk community birthing and are making a strong recommendation to the newly elected legislature. There are some major cut-backs ($100 million deficit forecast by March 31, 1996) with re-organizational changes and downsizing taking place in the Health and Social Services sector. (The Birthing Project consultant's position was made redundant. She has moved from the NWT but maintains her role).

Prince Edward Island

There is nothing new regarding midwifery. The past president has moved to Halifax so now there are two Association members.

New Brunswick

There are a few home births in this province. Transitions, the consumer group, has been low keyed. There are frequent requests for labour support and a person has started a private Doula practice.

Nova Scotia

The Midwifery Option Project is funded by a provincially awarded grant for the purpose of widening the base of midwifery education within the Halifax-Dartmouth area. It is estimated that 300 people received the information and the response has been most favourable. A midwifery information package has been assembled to give to each Regional Health Board. The package contains information about Nova Scotia and the rest of Canada.

There is a growing demand for midwifery education. The women have been voicing their frustration about the lack of accessability to midwifery training. The Association of Nova Scotia Midwives has completed a vision statement and is working on Standards of Care. The midwives who provide home births are kept busy.

The Association of Nova Scotia Midwives has members on the Planning Committee for the Low Intervention Unit at the Grace Maternity Hospital in Halifax. Two people have recently been hired to share the position of Head Coordinator. Data are being collected through interviews with hospital physicians, nurses, and mother who would be potential users of this service. The data will provide information as to how hospital staff view the unit working and what birthing women feel best serves them. The unit is scheduled to open in the early spring, 1996.

Newfoundland

During the summer the Newfoundland and Labrador Midwives Association members in the St. John's area worked with the Friends of Midwifery support group in lobbying government and health boards in this part of the province. The Friends of Midwifery are continuing the lobbying for the legalisation of midwifery.

At present the only hospital in the eastern part of the Avalon Peninsula which has an obstetric unit is the S.A. Grace General Hospital in St. John's. This is one of the hospitals which is being closed by September 1998. Obstetrics is to be moved to the General Hospital (the trauma centre for the province) at the Health Sciences Centre (and high risk neonatal care will be separate from maternal care). When lobbying the Chief Executive Officer of the Health Care Corporation of St. John's we asked for birthing rooms and midwives to be allowed to practice in the unit. Of course, the allowing of midwives to practice is a provincial government decision. Officially, midwives are only allowed to practice in the northern area (which has now been divided into two separate health boards).

The demand for labour support persons continues. Robyn Beaudry and Kay Matthews try to meet some of this demand. Often women are looking for a birth with a midwife, especially if they have recently moved from the mainland. Some women become very upset and aggressive when told that midwife assisted births are not available

in Newfoundland.

Pearl represents Canadian midwives on the following committees:
Canadian Expert Working Group on Breastfeeding which meets in Ottawa once a year and at other times by telephone.
Canadian Perinatal Surveillance Systems Steering Committee which meets every three or four months. Indicators are being decided on and a draft form should be available by the April meeting. If the same form is used for all births in the country then similarities and differences can be compared.
Joint Statement on Fetal Alcohol Syndrome/Fetal Alcohol Effect. This Statement is in the final phase of being agreed upon and printed. A copy will be requested for each Alliance member.

Charlene Maclellan from the Midwives Association of Nova Scotia represents Canadian midwives on the rewriting of the **Family-Centred Maternity and Newborn Care National Guidelines**.
A midwife has just been nominated to represent Canadian midwives on the **Canadian Coalition for the Prevention of Development Disabilities**.
A call is out for a midwife who is in good standing with her provincial midwives association, which is a member of the Canadian Confederation of Midwives, to be nominated to represent midwives on the **National Neonatal Resuscitation Program** committee. If you are interested and are practising as a midwife, have passed the NRP examinations, are a paid-up member of the Alliance, and have funding to attend out of province meetings, advise Pearl a.s.a.p. The CCM/CCSF does have some requirements which must be kept, e.g. the regular attendance at the NRP meetings and submitting of reports to the CCM/CCSF.
The CCM/CCSF has also had input into the **CPHA Midwifery Position Statement support paper**.

Letters from Away
From Karene Tweedie, 24m Winton Drive, Glasgow G12 0QA (Telephone: 0141-339-9845 (omit the 0 if phoning from Canada)).

October. Well here I am in Glasgow for better or worse. I am readjusting to Scottish and student life again. You are right. I have become more Canadianized than I realized.

The masters of nursing and the masters of midwifery students take some courses together. I am in the rather unfortunate situation of finding myself to be the only midwifery student taking the course full time. There are only four full time nursing students. Everyone else seems to be working and studying part time. Our situations vary from no financial assistance (me) to full salary. The biggest challenge seems to be finding material. Although the library is the most modern in Europe and one of the biggest, its priority does not seem to be with nursing or midwifery books or journals.

It is all very exciting. I do have my work cut out for me though. I am living in a flat for postgrads in Kelvinside, which is

a "posh" part of Glasgow. I walk through the Botanic Gardens to University which takes 25 minutes. That's quite pleasant. I can escape from the city into the park quite quickly. I live with an Iranian who is a PhD student in soil science and a Russian doctor who is completing the final year of medical school here to prepare her for the U.K. exams. It is very interesting learning about Iran and Russia from the insider's point of view. I am spending a lot of time teaching English. It is too bad I am not receiving a salary for it!

Please convey my thanks to the Alliance for the beautiful picture. I have always admired that one [a framed print by Catherine Munro of brightly coloured downtown row houses in the winter]. Thanks too to Clare for taking time from her lunch break to catch me at Pizza Experts. It was very kind of her.

I hope that the Alliance has a successful year. Let me know when I have to pay my dues!

December. I am up to my eyes in reading assignments, exam prep, computer courses, my research proposal etc. etc. I persuaded Dad to go to NF without me for Christmas. I am going to Ireland for a few days and have an assignment which will take care of most of my vacation. I am readjusting to my new life but I had hoped for more free time to visit friends up and down the country. There just does not seem to be enough time to do what I want!

I hope everything is going well on the Rock. How is the Alliance? Best wishes for 1996.

From Sharon Ransom, 6620 Dalrymple Way N.W., Calgary, AB T3A 1R9 (Telephone: 403-286-0277)

November. How are things in St. John's? We are very nearly all settled in here. We purchased a new house (new to us) 22 years old. It is quite nice, beautifully landscaped, but smaller than our St. John's home.

I have not looked into the midwifery movement here nor nursing yet, but will after Christmas. Happy New Year. All the best to the Midwifery Group.

Recent Articles by Alliance Members

Matthews, et al. (1995). Infant feeding practices in Newfoundland and Labrador. Canadian Journal of Public Health, 86, 296-300.

McKim et al. (1995). The transition to home for mothers of healthy and initially ill newborn babies. Midwifery, 11, 184-194.

Another Article of Interest to Alliance Members

SOGC. (1995). Fetal health surveillance in labour. Journal SOGC, 17, 860-901.

Jaundice and Hypoglycaemia: Medical Problems that Work Against Breastfeeding, by Dr. Neil Campbell, neonatologist from Australia, at the 1993 ILCA conference in Arizona. Submitted by Pamela Browne.
Neonatal Jaundice. Jaundice is an abnormal accumulation of bilirubin. It is a normal breakdown product of haemoglobin and various other enzymes and chemicals in the body. A degree of jaundice is normal for all babies, i.e. physiological jaundice. The problem is that very high levels of bilirubin in the blood is thought to be toxic to the brain, i.e. bilirubin encephalopathy. The spectrum of the effects of bilirubin encephalopathy range from kernicterus (high mortality, or severe brain damage, cerebral palsy and deafness in babies who do survive) to minimal cerebral dysfunction.

The problems associated with breastfeeding and jaundice include:

1. It has been believed for a long time that breastfed babies become more jaundiced in the first few day of life than artificially fed babies. Is this true? More recent studies show that breastfed babies do not become more jaundiced, or if they do there is only a very slight difference. Studies that have examined the issue show that breastfed babies who are appropriately and effectively breastfed have the same amount or less jaundice than artificially fed babies. However, in contrast, breastfed babies who feed inappropriately will become more jaundiced than artificially fed babies. Appropriate breastfed means an early start to breastfeeding; rooming-in; frequent and unrestricted breastfeeding especially in the first couple of days; no complementary feeds; active support and accurate information regarding breastfeeding.

2. Phototherapy - causes lactose intolerance, resulting in diarrhoea, which causes many physicians to say we should stop feeding these babies milk that contains lactose. Phototherapy is very effective treatment for jaundice. Unfortunately the bilirubin breakdown products that are excreted into the bowel are toxic to and injure the bowel's delicate lining, resulting in diarrhoea, with an intolerance to lactose. Therefore, phototherapy can hinder breastfeeding, especially when it often involves readmission to hospital, separation, frequent blood testing. It is not known what levels of bilirubin are dangerous for particular babies. It is believed that the danger level varies from baby to baby, based on gestational age and whether the baby has other problems, e.g. hypoxia during labour and delivery, hypoglycaemia, causes of jaundice. Scientists are now believing that only jaundice that is caused by haemolysis are dangerous to the baby, that non-haemolytic causes of jaundice do not put the baby at risk at all. Serum bilirubin guidelines are based on educated guesswork only.
For haemolytic diseases a mature baby is thought to be able to tolerate a serum bilirubin >350 mmol/L, a very premature (<30 weeks) can tolerate about 220 mmol/L.
For non-haemolytic causes a mature baby can tolerate >400 mmol/L (and possibly >450 mmol/L), for very premature babies the level of tolerance is not known.

Therefore, it is important to exclude haemolytic diseases and infections. Current available evidence suggests that mature babies do not need phototherapy unless they have a haemolytic cause or the serum bilirubin is >300-350 mmol/L.

Although phototherapy is less effective if used in a stop start manner, it is not grossly less effective. Breastfed babies need to have their phototherapy frequently interrupted to allow for frequent breastfeeding with eye patches off. Frequency of breastfeeding should be increased with phototherapy not decreased. All physicians have been trained that babies under phototherapy will need a lot more fluid intake because of insensible loss. It is true that phototherapy can increase water loss, in fact up to 50%. There have been many studies regarding what this insensible water loss actually means. A normal baby under normal circumstances looses 0.5-0.7 ml/kg/hour, which equals 6 ml/kg/day. If phototherapy increases water loss by 50% then babies under phototherapy will need an increased fluid intake of 9 ml/kg/day. A 3 kg baby under phototherapy would then need an extra 27 ml/day. If the baby is being breastfed in the appropriate way he will be getting way more than his basic fluid needs met. Even if the baby under lights is passing "phototherapy stools" i.e. green squirty diarrhoea-like stools, if he is being appropriately breastfed his fluid needs will be met. Some physicians test these phototherapy stools for lactose and if present discontinue breastfeeding. However, this is not appropriate treatment because all babies' stools contain lactose. This test should be ignored for breastfed babies under phototherapy.

If the diarrhoea should become worse leading to evidence of dehydration: 1. review need for phototherapy; 2. if diarrhoea continues and phototherapy is still necessary, establishment of lactation should be seen as being important and, therefore, intravenous therapy is the most appropriate treatment as it allows breastfeeding to continue unhindered by complementary artificial feeds.

3. Breastmilk jaundice persists beyond 6 days after birth, i.e. beyond physiological jaundice. The serum bilirubin levels of these babies are usually far higher than those with only physiological jaundice, and the jaundice lingers for many weeks, sometimes months. All pathological tests are normal. The cause is still not certain and there are no long term harmful effects. The main problem with breastmilk jaundice is anxiety (usually in the physician). Management includes elimination of possible pathological causes by blood testing. However, it is suggested that if the baby is otherwise well, and if all babies are routinely tested for hypothyroidism (which can cause jaundice and permanent mental retardation), and if bilirubin is unconjugated, then it can be debated as to whether intensive blood work-up is necessary. Some physicians discontinue breastfeeding for <48 hours to confirm the diagnosis. However, Dr. Campbell does not feel that this method is justifiable because it treats the medical staff but jeopardizes the baby's breastfeeding experience. Is there any level of breastmilk

jaundice that should be treated with phototherapy? No one knows. However, if the levels of jaundice become extremely high, e.g. >400 mmol/L, phototherapy is probably useful until the serum bilirubin decreases to <400 mmol/L.

Hypoglycaemia. Glucose is a vital metabolic fuel for the body, especially the brain. Low blood sugar levels can cause brain damage. However, it is not known at what blood sugar level below which a baby can get brain damage, or whether there is a time factor involved. Is it a slightly lower blood sugar level for a long period of time? Or is it a very low blood sugar level for a short period of time? Some studies suggest that it is only extremely low, e.g. 0 mmol/L, levels especially if the baby has symptoms such as convulsions, that can cause damage. However, more recent studies suggest that a milder degree of hypoglycaemia over several days can also cause brain damage. Therefore, there are no absolutes in blood sugar levels and safety for babies. There does appear to be different ranges of safety for different babies.

Danger blood sugar levels depend on how long the blood sugar level has been low, and on the other conditions the baby has, e.g. prematurity, respiratory distress syndrome, asphyxia. Well babies with lowish blood sugar levels seem to be at no risk.
Extremely low levels, <1 mmol/L, place ill/premature babies at risk of brain damage.
Moderately low levels, about 2 mmol/L, for more than 4 days may also put the baby at risk.
Mildly premature babies, 35-37 weeks, and mildly small for dates babies with transient lowish blood sugar levels in the first 24-36 hours who are otherwise well, are not at risk of any brain damage. So the treating of these babies with observation in isolettes, frequent blood taking and high volume artificial feeds in the first days is not only unnecessary but also works against the successful establishment of lactation. Therefore, it is very important to only treat those babies who are truly at risk.

There is no adequate scientific evidence to prove that early supplementary feeding is of benefit in preventing brain damage from hypoglycaemia. However there is evidence proving that hypoglycaemia can persist despite aggressive early artificial feeding. Therefore, early aggressive artificial feeding will not protect the babies who are seriously at risk. On the other hand, it interferes with lactation for many babies who are not really at risk.

There are also problems with methods used to test blood sugar levels. Strips are frequently inaccurate. The method of blood collecting and testing with strips and monitors needs to be very precise, otherwise results will be inaccurate. Laboratory measurement is the only accurate way of measuring blood sugar levels.

Therefore, we should accept mild hypoglycaemia in babies who are well, or a little premature, or a little small for dates. We should establish lactation for these babies in the usual way, with maybe the occasional laboratory test for staff comfort.

Treatment for babies really at risk: Intravenous glucose with glucagon to control blood sugar levels; use laboratory testing only; establish lactation in the usual way without artificial supplementation; no artificial forced feeding.

<u>BC Women's First in Canada to Pay for all Infant Formula</u>
Media Release, September 14, 1995.
British Columbia's Women's Hospital and Health Centre Society Board of Directors today announced that Canada's largest obstetrical facility will pay for all infant formula.
The policy of paying for formula will be monitored closely and reviewed in one year to determine if formula use decreases. BC Women's had formerly accepted free formula, but did not accept grants offered by formula companies.
This major step is part of BC Women's ongoing commitment to promoting and supporting breastfeeding. The World Health Organization (WHO) and UNICEF, as well as the B.C. Ministry of Health, have been most emphatic that hospitals refuse free formula as an integral part of their efforts to promote breastfeeding.
Paying for formula will not by itself, promote breastfeeding. Greater staff awareness and public perception is vital. We believe that paying for formula may make us more disciplined in its distribution and use.
Research has shown that breast fed babies and their mothers are healthier. As a leader in women's health, BC Women's will continue to make every effort to increase breastfeeding rates in our facility and our province.
As with all previous formula contracts, BC Women's will choose the supplier by the nutritional content of the product.
For more information, please call BC Women's Community Relations 604-875-2383.

The following actions comprise <u>BC Women's Ten Step plan</u> to promote successful breastfeeding.

1. Develop and communicate a breastfeeding policy to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Educate all pregnant women about the benefits and management of breastfeeding.
4. Develop procedures that support the start of breastfeeding within half-hour of birth.
5. Show mothers how to breastfeed and how to maintain milk supply even when separated from their infants.
6. Newborns to be given no food or drink other than breast milk unless medically indicated.
7. Allow mothers and infants to stay together 24-hours-a-day.
8. Encourage breastfeeding on demand.
9. All types of rubber nipples to be avoided.
10. Mothers to be provided with information on breastfeeding support groups and community resources.

<u>BC Women's Breastfeeding facts</u>:
80% of women who come to BC Women's intend to breastfeed
- of these 40% breastfeed exclusively
- after six weeks more than 80% were still breastfeeding, and half of those were breastfeeding exclusively.
- staff committee established to institute Baby Friendly initiatives;
- employ seven lactation consultants;
- personal in-patient consultation three days a week;
- out-patient clinics twice a week;
- offer pre-natal breastfeeding classes three times a month;
- from April 1994-March 1995
  970 attended outpatient drop-in clinics,
  989 had postpartum consultation,
  622 attended prenatal breastfeeding classes;
- resource centre for, and liaison with Vancouver Health Dept. physicians, other facilities, and health organizations across B.C.;
- produced two breastfeeding videos, shown on our internal education channel;
- made video for other hospitals and staff education;
- two breast pumps available (24 hour access) with on-site pump room for staff/patients;
- produced a number of pamphlets supporting breastfeeding;
- developed "learning package" for health professional education;
- identified need and developed comprehensive staff education program;
- breast pump demonstrations for staff/patients;
- produced resource list for parents.

<u>BC Women's Formula facts</u>:
Quantity of formula used annually at BC Women's:
approx. 8,000 litres/year
Cost of formula used annually at BC Women's: up to $60,000/year

<u>Breastfeeding Promotional Package</u>

This Promotional Package includes posters, 3½ in. disk. It is available from Andrea Donlan, Health Canada, telephone: 613-954-8842.

<u>Studies of Attitudes on Breastfeeding</u>

The data for this attitude study were collected from women across Canada. The report has been finalized and is being printed in French and English. It will also be available electronically on the Health Promotion ON-LINE. Requests for copies to Marie Labreche, Health Canada, telephone: 613-957-8344;
fax: 613-954-3358.

Statements and Reports on Breastfeeding - Relevant to Midwives

The Nurses Association of New Brunswick (NANB) submitted a Position Statement on Breastfeeding to the NANB Board in May 1995.

The Registered Nurses Association of Ontario (RNAO) passed a Position Statement on Breastfeeding in January 1995.

In 1995 the Northwest Territories Registered Nurses Association (NWTRNA) is releasing a report on the breastfeeding practices of babies born in 1993.

The Canadian Pharmaceutical Association approved a position statement on Breastfeeding and Infant Nutrition in May 1995.

Long Hours Standing May Put Unborn at Risk - from Evening Telegram, 117(163), September 16, 1995, p. 19.

Pregnant women who stand for long hours or work in a noisy, stressful atmosphere for more than 40 hours a week can increase their risk of giving birth prematurely by about 70%, researchers say. A study of 1,470 pregnant nurses showed that those who worked around roaring machines, or stood for long periods while caring for newborns, or who worked unusually long and irregular schedules were much more likely to deliver premature, underweight babies. Results of the study are published in the American Journal of Obstetrics and Gynecology. Dr. Timothy Johnson, chairman of obstetrics and gynecology at the University of Michigan, Ann Arbor, said the research should send a clear signal to working women to consider modifying their work habits during pregnancy. Johnson said the study showed that women who already have given birth to a premature baby are about 10 times more likely to do so again if they work and stand long hours in stressful conditions. He said women who have had a previous preterm delivery "should seriously consider whether they want to work at all".

No Inquest in Baby's Death - from Evening Telegram, 117(170), September 23, 1995, p. 14.

No inquest will be held in the death of a baby who was dropped on the floor of a hospital delivery room shortly after birth, a Niagara Region coroner announced Friday. . . . It's the only dropping death in a delivery room reported to the coroner's office. Dr. Porter said no further investigation is warranted, but made the following recommendations:

- The delivery physician or midwife should be responsible for transporting newborns;
- The transfer of an infant from one person to another should occur over a raised surface such as a bed, table or cot;
- A newborn should be carried to another person or a neonatal warmer in a towel or blanket;
- The person receiving an infant should say he or she has a secure hold.

Steroids and Premature Babies

A world wide study involving 60 centres is being coordinated from Belfast. Included are the U.K., other European countries, Israel, Canada. Findings from preliminary studies in the U.S.A. have suggested that giving steroids to preterm babies reduces the time that they require additional oxygen and therefore they can come off ventilators earlier. (The risk of lung damage to babies increases the longer they stay on mechanical ventilation). The purpose of the study is: to determine the optimal time to give steroids to ill, preterm babies after birth; to compare steroids given either orally or by intravenous infusion with those given by an inhaler. It is hoped to recruit 1200 babies into the study, and by the summer they had 250 babies. (Action Research is funding this. They fund many projects involving preterm babies).
(cited in Midwives, 108, p. 307, September 1995)

Waterbirth booklet

The National Childbirth Trust (NCT) has a new publication entitled Labour and Birth in Water, price 75p plus postage. Procedures for labour and birth, the benefits and possible problems, are presented based on the results of the most recent research. Available from NCT Maternity Sales, Burnfield Avenue, Glasgow G46 7TL, Scotland.

British National Health Service Numbers

The NHS has started to use 10 digit numbers and by April 1997 all patients will be required to have such a number. (In the past there has been a mixture of letters and numbers). Having numbers only will make it easier to computerize information. For information regarding this and other infrastructure projects write for a list of publications to the Information Management and Technology Information Point/NHS Register of Computer Applications, NHS Executive, c/o Cambridge & Huntingdon Health Commission, Primrose Lane, Huntingdon PE18 6SE, England.

British Folic Acid Campaign

Research has found that only half of the women studied knew that folic acid could help to prevent spina bifida. Therefore, the Health Education Authority is to start a £2.3 million public information campaign to encourage women to increase their folic acid intake before conception and during the early months of pregnancy; so as to reduce the numbers of babies born with neural tube defects. Information will be aimed at all women of child-bearing age and their partners, family physicians, nurses and other health professionals involved with advising and informing prospective parents. To try to increase the folic acid intake of all women, as many pregnancies are unplanned, food manufacturers will also be encouraged to increase the range of foods fortified with folic acid, e.g. bread and breakfast cereals.
(cited in Midwives, 108, p. 305, September 1995).

Midwifery in the U.K.

"It is a matter of the utmost concern that the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) recent secretive organisational review of its committee and management structure was carried out without a midwifery representative being invited to participate. Most midwives are aware that their profession's interests within the UKCC are the province of the Midwifery Committee which, under the terms of the 1979 and 1992 Nurses, Midwives and Health Visitors Acts, has the statutory right to have referred to it, to consider and to advise on, all matters related to midwifery. Just who decides what is a 'midwifery matter' is, unfortunately, unclear.

A few years ago, the English National Board (ENB) decided that it could do away with midwifery education officer posts and reorganise them into generic education posts because, it claimed, such a move was a management and not a midwifery issue. The furore over the ENB's disregard of the wishes and advice of its (elected) Midwifery Committee was encapsulated in Margaret Brain's Presidential Address to the 1993 RCM Annual Conference: 'If we lose control of our education, we lose control of our profession'. . . .

The proceedings of the UKCC's many and lengthy closed sessions cannot be scrutinised because the minutes are not made public.

. . . There is a well-functioning and respected Midwifery Committee. . . . The more we see of joint statutory bodies, the clearer the case for separate legislation of midwives becomes. A Draft Midwives Bill is available (£3 inc. p. & p.) from the Association of Radical Midwives, 62 Greetby Hill, Ormskirk, Lancs L39 3DT, England). (Hughes, D. (1995). Is midwifery safe in the embrace of the UKCC? (editorial). Midwives, 108, p. 282)

Money for Breastfeeding

The British government is spending £130,000.00 on encouraging new mothers to breastfeed. A £50,000.00 training package for health professionals; £30,000.00 to support new good practice guidance for the National Health Service; and £53,000 which was spent on leaflets and posters promoting the National Breastfeeding Awareness Week. Moors, S. (1995). News from Parliament. MIDIRS Midwifery Digest, 5, 365).

Midwives leave NHS

During the three years up to September 1993 the number of nurses and midwives working in the National Health Service decreased by 33,900, but the number working in private hospitals, homes and clinics increased by 33,068. The NHS is having to spend hundreds of thousands of pounds in training fees. Labour's Health Secretary asked how the government could "deny that privatisation of our health service is happening and how can they deny that privatisation is damaging the NHS?" (Moors, S. (1995). News from Parliament. MIDIRS Midwifery Digest, 5, 365).

Feet to Foot Placement for Babies
The Foundation for the Study of Infant Deaths have advised parents to place their baby's feet at the foot of the crib. (The top half of the crib is left empty). Then there is no space for the baby to wriggle down to the bottom of the crib and get too hot under the bedding. Overheating is a recognised risk factor in SIDS. (Midwives, 109(1296), 20).

Health Sciences Library, MUN, Information - from Library Links, 9(1), September 1995.
Charges for Journal Photocopy Requests. Effective July 1, 1995, the Health Sciences Library began charging for journal or other photocopy requests from all clients in Newfoundland **who are not faculty or staff of Memorial University.** (Hospital staff of the former General Hospital Corporation are currently exempted from these charges). The following charges will be in effect: $2.50 per article. Books or audio-visual materials will still be loaned without charge. Requests submitted from libraries or others on behalf of Memorial faculty, staff, or students, must clearly identify the MUN affiliation and status of the requester or charges will be applied. Normally the filled photocopy requests will be sent out by mail, or by shuttle service where available. Special delivery mechanisms are available. For example, material can be faxed at an additional cost of $1.00 per page. (Further information from Document Delivery Section, Health Sciences Library, MUN. Telephone: 709-737-6628; Fax: 709-737-6866)
Health Sciences Library collection Development Update. For the 1995/96 fiscal year there will not be any significant cancellation of journal subscriptions. A small number of journals which have been identified as low use, and/or low importance, may be cancelled as part of the library's ongoing efforts to maintain a quality collection appropriate to the needs of library users. The funding available for purchase of books, audio-visual materials and computer assisted learning software has decreased for 1995/96. The library is currently conducting a detailed review of usage of the book collection, with the aid of a MUCEP student, in order to determine the potential for prioritizing use of the available funds. If there are any questions about the library collections or suggestions for additions, do not hesitate to contact George Beckett at 737-6670.
Cosession Telephone remote access to the library has been abandoned due to technical problems. The library is currently investigating various options and testing new software. At present the only remote access available is via telnet. Those who are affiliated with the university can obtain an account from the Computing and Communications Dept., Henrietta Harvey Building (737-8117).
World Wide Web. If anyone has discovered (or created!) a medical/health source of particular interest on the Internet or Web, Catherine Sheehan, Health Sciences Library would like to hear of suggestions/comments. (Telephone 737-6672; e-mail: csheehan@ morgan.ucs.mun.ca). She is trying to locate important and quality resources.

Former Federal Public Service Employees - You may be eligible for Money from a Wage Adjustment

Nurses and others who have been employed by the Federal Government since April 1, 1987, should contact their last employing department or agency, identifying their last name, address, social insurance number or personal record identifier number and the last day worked. (If a dependent of someone who died provide this information plus own full name). On May 31, 1995, a Tribunal approved an equal pay settlement negotiated between Treasury Board Secretariat and the Professional Institute of the Public Service of Canada. Applications have to be made before March 31, 1996.

Conference Calendar

Up to $500 is available annually to a member, whose Alliance registration fees are paid up-to-date, to help pay the cost of attending a conference which is in keeping with the Alliance objectives of care to women and babies. So that members are aware of the conferences being offered it has been suggested that we list those which may be of interest. Just because a conference is listed does not mean that it necessarily meets the Alliance objectives. (The next money available is for 1996). If you know of any conferences, meetings, etc. which could be of interest to members please forward the information to the editor for inclusion in the Newsletter. For International Conferences the call for Abstracts is usually one year or more before the conference date. Often only mailed, not faxed, abstracts are considered. (Readers are responsible for checking the information of the conferences listed. As the information comes from a variety of sources the Editor accepts no responsibility for any misinformation).

1996

Jan. 27-Feb. 3. "C.E.'S @ SEA" 4th Neonatal-Perinatal conference at sea. Sails from Miami to St. Thomas, St. Marten and San Juan, Puerto Rico.
Cost: From $1119 US per person includes conference/cruise and air prices. Registration limited to 100 participants.
Contact: Barbara Quinn Telephone: 1-513-395-8471.

Jan. 29. "Community Health and the Health Care Corporation" by Elizabeth M. Davis. 1200 to 1300. Community Medicine Seminar Series, HSC Lecture Theatre D. Snacks and coffee will be served.

Jan. 30. "Computers and Nursing Education", MUN School of Nursing, Room 2908, at 4 p.m. (Telephone conference to the Western Memorial School of Nursing in Corner Brook). Presenters are Janet Curran-Smith and Marianne Lamb. A seminar organized by the Faculty Development Committee.

Feb. 6. "Promoting Breastfeeding: Taking an Active Role", by the Western Regional Health Planning Committee. ARNN Continuing Nursing Education Teleconference at 1415 to 1530 (Island time).

Feb. 15-16. "Frontiers in Nursing: Care of the Very Low Birthweight Infant", Salt Lake City, Utah.
Contact: Jan LaBard, 50 No., Medical Drive, University of Utah Health Sciences Centre, Salt Lake City, Utah 84109 (Telephone: 801-581-2394)

Feb. 20. "Acupuncture" by Ethne Munden and Maura Beam, Newfoundland and Labrador Holistic Nurses' Association. ARNN Continuing Nursing Education Teleconference at 1415 to 1530 (Island time).

Feb. 26. "Strategies for Improving Health and Well-being". Some preliminary findings of the health component of the Tri-Council Eco-Research Project on Sustainability in a Changing Cold Ocean Coastal Environment, by Shirley Solberg. 1200 to 1300. Community Medicine Seminar Series, HSC Lecture Theatre D. Snacks and coffee will be served.

Feb. 29-March 3. Midwifery Today International Conference, Hawaii.
Contact: Midwifery Today, PO Box 2672-242, Eugene, OR 97402, USA (Fax: 503-34401422) (e-mail: midwifery@aol.com)

March ? Caribbean International Conference, San Juan, Puerto Rico
Contact: Midwifery Today, P.O. Box 2672-242, Eugene, OR 97402 (Fax: 503-344-1422) (Email: Midwifery@aol.com)

March 5-7. "Nursing and Midwifery - Making a Difference in Health for All". First Global Network of WHO Collaborating Centres for Nursing and Midwifery Conference, Bahrain.
Contact: Global WHO Network for Nursing Midwifery Conference, P.O. Box 26959 Al-Adliya, State of Bahrain. (Fax: 973-276905).

March 12. "Advanced Nursing and Medical Nursing Shared Skills Who's Doing What? An Opportunity to Share Information" by the ARNN Nursing Practice Committee. ARNN Continuing Nursing Education Teleconference at 1415 to 1530 (Island time).

March 19. "Nurses' Perspective on Health Care Reform: ARNN Survey Results" by Christine Way and Jeanette Walsh. ARNN Continuing Nursing Education Teleconference at 1415 to 1530 (Island time).

March 20-21. "Informed Choice", Bristol, UK. How can you be sure that you are giving women current information?
Cost: £60 members, £80 non-members.
Contact: MIDIRS, 9 Elmdale Road, Bristol BS8 1SL, UK
(The annual subscription to join MIDIRS and receive the Midwifery Digest is £42 for overseas individuals).

March 25. "A Simple Remedy for a Major Problem: Neural Tube Defects and Folate Fortification of Flour" by Elizabeth Ives. 1200 to 1300. Community Medicine Seminar Series, HSC Lecture Theatre D. Snacks and coffee will be served.

March 29-31. "The Royal College of Nursing Annual Nursing Research Conference", Newcasdtle upon Tyne, England.
Cost: £327.83 for RCN members, £387.25 for others
Contact: Karen Waterman, Nurse Researcher, Conference and Exhibition Unit, Viking House, 17-19 Peterborough Road, Harrow, Middlesex HA1 2AX, UK (Fax: 44-181-423-4302)

March 30. "Caring for an Infant with a Cleft: The First Few Weeks of Life", Pittsburgh.
Contact: Cleft Palate Foundation (Telephone: 412-481-1376)

April 9. "$$Getting those Dollars. Strategies for Funding Nursing Research" by Newfoundland and Labrador Nursing Research Special Interest Group. ARNN Continuing Nursing Education Teleconference at 1415 to 1530 (Island time).

April 10-12. "First Biennial International Nursing and Midwifery Conference", Edinburgh, Scotland.
Contact: Carol Edgar, Course and Conference Organizer, Lothian College of Health Studies, 74 Canaan Lane, Edinburgh, EH10 4TB (Fax: 131-536-5623).

April 12. "Canadian Midwifery: The Growing Health Care Profession", Halifax, NS. Combined - Association of NS Midwives and Canadian Confederation of Midwives. April 13 the AGM of the CCM/CCSF to which midwives who are members in good standing with their midwives' association are invited to be observers.
Contact: Charlene Maclellan, RR 2, Canning, NS, B0P 1H0 (e-mail: rbent@acadiau.ca)

April 19-20. "Women's Health, Learning and Empowerment: Reflections, Research, Reality". ARCAUSN Annual Conference, Antigonish, NS. Keynote speaker: Afaf Meleis from UCSF
Abstracts: January 30, 1996.
Contact: Marion Alex, ARCAUSN Annual Conference, Dept. of Nursing, P.O. Box 5000, St. Francis Xavier University, Antigonish, NS B2G 2W5 (Fax: 902-867-2389)
April 22-24. "Perinatal Nursing: Issues and Trends for the Future", San Francisco, CA
Contact: Contemporary Forums, 11900 Silvergate Drive, Dept. 118, Dublin, CA 94568 (Telephone: 510-828-7100)

April 24-25. "Informed Choice", London, UK. How can you be sure that you are giving women current information?
Cost: £60 members, £80 non-members.
Contact: MIDIRS, 9 Elmdale Road, Bristol BS8 1SL, UK

April 24-26. "First International Congress of Nursing Childcare and 8th National Meeting", Toledo, Spain.
Contact: Prof. Dolores Ruiz, Enfermeria Infantil Escuela Universitaria de Enfermeria y Fisioterapia Pl., Santo Domingo el Antiguo, s/n 45002 Toledo, Spain. (Fax: 34-25 26 88 11/22 78 30)

April 27. ASPO/Lamaze certification examination
Deadline for application: March 1, 1996
Contact: ASPO/Lamaze, 1200 19th Street NW, Suite 300, Washington, DC 20036 (Telephone: 1-800-368-4404)

May 1996. Foreign-Trained Midwives pre-certification program. Successful completion qualifies person to take the American College of Nurse Midwives certification exam.
Contact: Diana Simonpietri CNM, Ramsey Clinic, St. Paul, MN (Telephone: 612-221-3820)

May 3-4. "New Visions", 11th Annual Conference and AGM of the Canadian Association for Nurses in Independent Practice, Alliston.
Contact: Mary McCaffrey (Fax: 519-747-5003)

May 3-4. "Conquering Mountains: New Vistas for Nursing in the 21st Century", 7th National COGNN conference, Kananaskis, Alberta. Themes are women's health, neonatal or obstetric nursing practice, education or administration. Speakers include Abby Hoffman, Sharon Wood, Nancy Betkowski, Inge Schamborzki.
Abstracts: Due October 1, 1995.
Contact: Colleen Stainton, Faculty of Nursing, University of Calgary, 2500 University Drive N.W., Calgary, AB T2N 1N4 (Fax: 403-284-4803) or Noreen Linton, 1716 42nd Street NE, Calgary, AB T1Y 2L7 (phone: 403-280-9645)

May 6-10. One week family nursing unit externship program, Calgary.
Contact: Marlene Baier, Administrative Secretary, Family Nursing Unit, Faculty of Nursing, University of Calgary, 2500 University Drive NW, Calgary, AB T2N 1N4 (Fax: 403-284-4803) (e-mail: baier@acs.ucalgary.ca)

May 21. "Managing by Information Update: Nursing/Ambulatory Care Guidelines" by MIS Steering Committee. ARNN Continuing Nursing Education Teleconference at 1415 to 1530 (Island time).

May 21-22. "Informed Choice", Manchester, UK. How can you be sure that you are giving women current information?
Cost: £60 members, £80 non-members.
Contact: MIDIRS, 9 Elmdale Road, Bristol BS8 1SL, UK
(The annual subscription to join MIDIRS and receive the Midwifery Digest is £42 for overseas individuals).

May 26-29. "Reproductive Endocrinology", Hilton Head Island, SC
Contact: Conference Coordinator, Johns Hopkins Medical Institutions (Telephone: 410-955-2959).

May 26-28. "The Quest for Quality: Questioning Nursing Practice". ARNN Annual Meeting, St. John's.
Abstracts: March 15, 1996.
Contact: ARNN, P.O. Box 6116, St. John's, NF A1C 5X8 (Fax: 709-753-4940)

May 26-30. "Quality in Health Care", 13th International ISQua Conference, Jerusalem.
Contact: Conference Secretariat, ISAS International Seminars, P.O. Box 574, Jerusalem, Israel (Fax: 972-265-20558).

May 26-31. "The Art and Science of Midwifery gives Birth to a Better Future". The 24th Triennial Congress of the International Confederation of Midwives, Oslo, Norway.
Abstracts: June 1, 1995. Completed papers in by December 1.
Main themes: Reproduction and infant health; Cultural differences in childbirth practice and midwifery; Psychological aspects of childbirth; Psychological aspects of childbirth, women's experiences; Midwifery education, research and leadership.
Cost: Before October 30 - NOK 4000; October 31 to February 28 - NOK 4900; March 1, 1996 onwards - NOK 5900.
(NOK = approx. 22 Cdn. cents)
Contact: Team Congress, P.O. Box 6, N-6860, Sandane, Norway. (Fax: 47-57-866-025).
For questions about the scientific programme contact: Norwegian Association of Midwives, Tollbugt, 35, N-0157, Oslo, Norway. (Fax: 47-2-242-2207).
Accommodation prices: Between NOK 185-1500 depending on category of hotel and if a double or single room. Price includes breakfast.
(The ICM journal International Midwifery Matters is published by the ICM, 10 Barley Mow Passage, Chiswick, London W4 4PH, UK, and costs £12 per year).

May 27-29. ARNN 42nd Annual Meeting, St. John's.
Contact: ARNN, P.O. Box 6116, St. John's, NF A1C 5X8
(Fax: 709-753-4940).

May 30-31. "The Advanced Practice Nurse: From Role Chaos to Role Clarity", Portland, MA
Contact: Irene Bise, CNS Section, Dartmouth Hitchcock Medical Centre (Telephone: 603-650-1523)

June 2-6. AWHONN 1996 Convention, Anaheim, California. Enhance knowledge, skills and talents to make critical choices in directing care for women and newborns.
Contact: Denise Savage, AWHONN, 700 14th St., N.W., Suite 600, Washington, D.C., 20005-2019 (Fax: 202-737-0575).

June 11. "Consumer Empowerment" by Delores Flynn, Newfoundland Association for Community Living and Joan Rowsell, ARNN. ARNN Continuing Nursing Education Teleconference at 1415 to 1530 (Island time).

June 6-7. "Breastfeeding Continuum: Strategies for Action". Sixth Annual National Breastfeeding Conference INFACT Canada/Women's College Hospital/ Humber College/Etobicoke Public Health Dept. Strategies, governmental policies, cultural norms, technology, research on education of health care professionals, future directions. Speakers include James McKenna and Paula Meier.
Abstracts: January 31, 1996, not more than 300 words.
Contact: Sylvia Segal, School of Health Sciences, Humber College, 205 Humber College Blvd., Etobicoke, ON M9W 5L7 (Fax: 416-675-2015)

June 13-16. "Beyond Medical Care: Policies for Health", 9th Congress of the International Association of Health Policy (IAHP), Montreal.
The conference will examine national and international issues regarding policies related to the non-medical determinants of health, as well as those related to the organization and financing of health care services.
Contact: Bureau de consultation et d'organisation de congres, Universite de Montreal, Case postale 6128, succ. Centre-ville, Montreal, Quebec, H3C 3J7 (Fax: 514-343-6544).

June 14-15. "Primary Health Care - into the 21st Century", London, U.K. Two day international conference to adopt themes from the WHO declaration of Alma Ata (1978) regarding the practice of primary health care.
Cost: £200+VAT for RCN members and overseas delegates; £293.75 for others.
Contact: June Cadogan, Conference Executive, Nursing Standard, Conference and Exhibition Unit, Viking House, 17-19 Harrow, Middlesex HA1 2AX England. (Fax: 44-181-423-4302)

June 16-19. Canadian Nurses Association annual meeting and Biennial Convention, Halifax
Contact: Canadian Nurses Association, 50 Driveway, Ottawa, ON K2P 1E2 (Fax: 613-237-3520; telephone: 1-800-361-8404).

June 24-27. "Research on Nursing Throughout the Life Span". Eighth Biennial Conference of the Workgroup of European Nurse Researchers, Stockholm, Sweden.
Contact: Stockholm Convention Bureau, P.O. Box 6911, S-102 39, Stockholm, Sweden. (Fax: 46-834-8441). or
Eva Szutkowska, Swedish Association of Health Officers, WENR, P.O. Box 32 60, 103 65, Stockholm, Sweden (Fax: 46-820-4096)

June 25-30. "5th International Week for Children's Rights: Children's Rights in the Global Economy", Montreal.
Cost: Training session $75; conference early (before Feb. 15) $300, late $400.
Contact: COPLANOR Congres Inc., 511 Place d'Armes no 600, Montreal, PQ, H2Y 2W7 (Fax: 514-288-6469) (e-mail: dei@coplanor.qc.ca)

June 27-30. Traditional Midwifery Conference, Eugene, OR
Contact: Midwifery Today, PO Box 2672-242, Eugene, OR 97402, USA (Fax: 503-34401422) (e-mail: midwifery@aol.com)

July 1-26. Certificate course in Breastfeeding: Practice and Policy, London, UK
Cost: £1450.00
Contact: Continuing Education Office, Institute of Child Health, 30 Guildford Street, London WC1N 1EH, UK (Fax: 44-171-831-0488)

July 2-5. "Health Promotion: 1986, 1996 . . . and Counting", CPHA 87th Annual Conference, Vancouver. Current status of health promotion, its role in health reform, changes in federal and provincial health and social policy and where public health fits in
Contact: Conference Coordinator, CPHA, Suite 400, 1565 Carling Avenue, Ottawa, ON K1Z 8R1 (Fax: 613-725-9826).

August 12-15. "Cancer Nursing - Creating the Future". The 9th International Conference on Cancer Nursing, Brighton, England.
Contact: June Cadogan, Conference Executive, Nursing Standard, Conference and Exhibition Unit, Viking House, 17-19 Harrow, Middlesex HA1 2AX England. (Fax: 44-181-423-4302)

August 15-18. "Celebrating our Diversity: 1996 ICEA International Convention", Washington.
Contact: Doris Olsen, ICEA, PO Box 20048, Minneapolis, MN 55420 (Fax: 612-854-8772)

August 22-24. "Making a World of Difference", 4th International Conference on Nurse Practitioner Practice, Edinburgh, Scotland. Organised by the Royal College of Nursing, American Academy of Nurse Practitioners, and University of Colorado Health Sciences Center School of Nursing.
Cost: £304.55 for RCN members and overseas delegates; £364.25 for non RCN members. (Accommodation from £34.50 per day).
Contact: June Cadogan, Conference Executive, Nursing Standard, Conference and Exhibition Unit, Viking House, 17-19 Harrow, Middlesex HA1 2AX England. (Fax: 44-181-423-4302)

August 28-31. New Zealand College of Midwives 1996 National Conference, Canterbury, NZ
Contact: Judy Henderson, NZCOM, PO Box 21-106, Christchurch, NZ (Telephone: 64-3377-2732)

Sept. 30-Oct. 3. "Nursing in the New Millennium. Beyond Tomorrow: Building Nursing Skills for the Future", Winnipeg. Innovation in nursing and nursing care delivery. Keynote speakers: Tim Porter-O'Grady and Angela Barron McBride. (Rescheduled).
Contact: Communication Dept., Manitoba Association of Registered Nurses, 647 Broadway, Winnipeg, MN R3C 0X2. (Fax: 204-775-6052).

Sept. ? Midwifery Today Florida-Caribbean International Conference. Contact: Midwifery Today, PO Box 2672-242, Eugene, OR 97402, USA (Fax: 503-34401422) (e-mail: midwifery@aol.com)

October 3. ASPO/Lamaze certification examination
Deadline for application: August 9, 1996
Contact: ASPO/Lamaze, 1200 19th Street NW, Suite 300, Washington, DC 20036 (Telephone: 1-800-368-4404)

October 14-18. "Breastfeeding: Science and Ethics, Theory and Practice", to be held in an Asian country. To look beyond the Innocenti Declaration by evaluating efforts since 1990, to build new commitments and to plan action in favour of breastfeeding. The forum is expected to mobilise, update, train and encourage sharing and networking.
Contact: Global Forum on Breastfeeding, c/o WABA Secretariat, P.O. Box 1200, 10850 Penang, Malaysia. (Fax: 60-4-657-2655)

November 3-6. "Appropriate Systems/Appropriate Decisions, Information Techology Issues in Community Health" ITCH '96 conference, Victoria, BC. Topics related to, but not limited, to application or technology.
STUDENT POSTER CONTEST: Full-time students, undergraduate or graduate programs, are invited to take part in a student poster contest. The winner will receive a cash prize and a complimentary full registration to the conference.
Contact: ITCH '96, c/o Conference Management, Division of Continuing Studies, University of Victoria, PO Box 3030, MS 8451, Victoria, BC V8W 3N6 (Fax: 604-721-8774; E-mail: ITCH@HSD.UVIC.CA)
October 30-November 2. "Tobacco-Free Canada". Second National Conference on Tobacco or Health, Ottawa. Policy making, access to information, research, support for community action, women, children, aboriginals, health professionals and tobacco etc.
Abstracts: February 23, 1996, on provided form.
Contact: c/o Taylor & Associates, P.O. Box 46066, 2339 Ogilvie Road, Gloucester, ON K1J 9M7 (Fax: 613-745-1846).
November 3-6. "Appropriate Systems/Appropriate Decisions, Information Techology Issues in Community Health" ITCH '96 conference, Victoria, BC. Topics related to, but not limited, to application or technology.
Abstract: By March 1, 1996. Up to 250 words by e-mail: ITCH@HSD.UVIC.CA or in ASCII text on diskette, or by mail.
Contact: ITCH '96, c/o Conference Management, Division of Continuing Studies, University of Victoria, PO Box 3030, MS 8451, Victoria, BC V8W 3N6 (Fax: 604-721-8774).

November 5-18. "Seventh International Congress on Women's Health Issues", Khon Kaen, Thailand.
Contact: Earmpon Thongkrajai RN, Associate Professor, Faculty of Nursing, Khon Kaen University, Khon Kaen 40002, Thailand (Fax: 043-237606 or 43-242106).

November 3-6. "Appropriate Systems/Appropriate Decisions, Information Techology Issues in Community Health" ITCH '96 conference, Victoria, BC. Topics related to, but not limited, to application or technology.
STUDENT POSTER CONTEST: Full-time students, undergraduate or graduate programs, are invited to take part in a student poster contest. The winner will receive a cash prize and a complimentary full registration to the conference.
Contact: ITCH '96, c/o Conference Management, Division of Continuing Studies, University of Victoria, PO Box 3030, MS 8451, Victoria, BC V8W 3N6 (Fax: 604-721-8774; E-mail: ITCH@HSD.UVIC.CA)

November 28-30. "Interdisciplinary Health Research Conference". Sponsored by the CNA, CNF, CNRG, CAUSN. Themes include collaboration with other disciplines, interdisciplinary work, multicentred research, fusion of research with practice.
Abstracts: March 1, 1996.
Contact: Conference Secretariat, c/o CAUSN, 350 Albert Street, Suite 325, Ottawa, ON K1R 1B1 (Fax: 613-563-7739) (e-mail: CAUSN@ACADVM1.UOTTAWA.CA)

1997
? Association of Radical Midwives 21st birthday celebration is being planned.
Contact: Ishbel Kargar, 62 Greetby Hill, Ormskirk, L39 2DT (Subscription of the ARM which includes the Midwifery Matters journal is £30 pa. The 1996 autumn issue of the journal is on overseas midwifery. Articles to be submitted by the beginning of July 1996. ARM items for sale include pinard stethoscopes £6 + pp)

June 15-20. "Sharing the Health Challenge", Vancouver. 21st ICN Quadrennial Congress. Topics include managing health resources, quality improvement, law and regulation, ethics and human rights, research, informatics, clinical, cultural, entrepreneurial, mental health, women's health, health promotion, care givers, etc.
Abstracts: before January 15, 1996.
Contact: Canadian Nurses Association, 50 Driveway, Ottawa, ON K2P 1E2 (Fax: 613-237-3520; telephone: 1-800-361-8404)
Education
Perinatal Education Partnership Project. Post-entry level baccalaureate education for registered nurses. Accessible through distance delivery.
Contact: Perinatal Education Partnership Project, 5980 University Avenue, Halifax, NS B3H 4N1 (Fax: 902-422-4463)

Clinical Issues Independent Study Modules (CHSM). Available from January 1996. The modules are based on the "Clinical Issues" articles published in JOGNN. The student needs the appropriate copy of JOGNN and the matching independent study module.
Cost per module: $10 for AWHONN members, $15 for non-members.
Contact: AWHONN, 700 14th Street NW, Suite 600, Washington, DC 20005-2019. (Fax: 202-737-0575) (e-mail: 73243,344@CompuServe.com)

Canadian Institute
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November 9, 1995

Dear Colleague,

We are extremely pleased to enclose a copy of the *Survey of Routine Maternity Care and Practices in Canadian Hospitals*, prepared by the Canadian Institute of Child Health. Health Canada has financially contributed to the development of this resource. Family and Child Health Unit, Population Health Directorate, Health Canada has provided additional funding to distribute the report. The Family and Child Health Unit is committed to improving the health and wellbeing of families and children, particularly children at risk, age zero to six.

The survey was conducted in the spring/summer of 1993 to determine the extent to which policies and practices in Canadian hospital maternity units were consistent with principles of family-centred care. The *Survey of Routine Maternity Care and Practices in Canadian Hospitals* provides a comprehensive picture of routine maternity care policies and practices in Canadian hospitals.

We ask you to share this publication with other individuals in your organization as appropriate. Perhaps you could deposit this copy of the *Survey* in a library or resource setting. We encourage you to refer people to CICH and to the investigators and co-investigators with enquiries.

Both the Family and Child Health Unit or Health Canada and CICH hope that you will find this publication to be a useful resource.

Sincerely yours,

Denise Avard
Executive Director

/encl.

HIGHLIGHTS

SURVEY OF ROUTINE MATERNITY CARE AND PRACTICES IN CANADIAN HOSPITALS

The survey was conducted in the spring/summer of 1993 to determine the extent to which policies and practices in Canadian hospital maternity units were consistent with principles of family-centred care.

The survey questionnaire was sent to all 576 hospitals that provide maternity care, as reported in the Canadian Hospital Association's Directory. Two call-backs were made to non-respondents. A total of 523 usable questionnaires were returned with an overall response rate of 91.4%. The response rate was over 80% for all provinces, the lowest rate being in Quebec (81.2%).

The questionnaire contained 90 main questions, which were organized into the following sections:

- *statistics*
- *family education*
- *labour and birth*
- *postpartum*
- *infant feeding*
- *policy development and committees*
- *physical facilities*
- *care immediately following birth*
- *support for families with premature babies*
- *loss and grief*

HIGHLIGHTS OF FINDINGS

◆ 76% of all respondents use the National Guidelines on Family-Centred Maternity and Newborn Care (Health and Welfare Canada, 1987).

- Provincially, the proportion of hospitals using the guidelines ranged from 94% in Ontario hospitals to 57% in Alberta.

◆ 45% of hospitals had an Ethics Committee, and 68% had a Maternal/Newborn (Perinatal) Committee.

- *Large hospitals were more likely to have committees than small hospitals.*

◆ The hospitals estimated that 60% (mean value) of women who give birth in their unit had attended childbirth education classes.

- *These values ranged from a low of 46% in Newfoundland to a high of 69% in Manitoba.*

◆ 30% of hospitals have only traditional delivery rooms available for birth. 70% have some type of combined room available.

- *Small hospitals were far more likely to have only traditional delivery rooms available.*

Health Canada Santé Canada

Canadian Institute of Child Health

- 55% of hospitals have epidural anaesthesia available for pain control.

  - *Larger hospitals are much more likely than are smaller hospitals to have this available for pain control.*

- Virtually all hospitals encourage partners to be present for cesarean birth with epidural anaesthesia.

  - *This ranges from a low of 55% in Newfoundland to a high of 100% in Prince Edward Island and the Yukon Territory.*

- In Canada, the hospitals estimated that 37% (mean value) of women give birth in lithotomy position with stirrups.

  - *This ranges from a low of 17% in British Columbia to a high of 61% in Quebec.*

- In Canada, the hospitals estimated that 70% of women having their first baby and 40% of women having their second or subsequent baby have an episiotomy.

- The mean average length of stay is 3.2 days for vaginal birth and 5.0 days for cesarean birth.

- The mean time nationally that babies room-in with their mothers is 16 hours per day.

  - *This varies from 6.5 hours in Quebec to 19 hours in Alberta.*

- 20% of hospitals have a policy for assessing women who may be going home to violent situations.

  - *Teaching hospitals are more likely to have this policy (56%) than were non-teaching hospitals (16%).*

- Hospitals estimated that 74% (mean value) of mothers are breastfeeding at the time of discharge.

  - *This varied from a low of 40% in Newfoundland to a high of 87% in British Columbia.*

- 24% of hospitals routinely give breastfeeding mothers sample packs of formula.

- 85% of hospitals with a neonatal intensive care unit/special care nursery encourage siblings to visit the newborn in the nursery. 91% encourage grandparents to do so.

- 98% of hospitals encourage parents to hold their baby in the event of a stillbirth or neonatal death. 63% provide a remembrance pack (i.e. photograph, lock of hair, clothing) to families who have lost their baby and 46% encourage them to meet with the perinatal bereavement group. 75% have a quiet room for families.

CHILD HEALTH

ISBN 0838-9683
Published Quarterly
Charitable Registration
Number: 0475137-11-10

The Newsletter of the Canadian Institute of Child Health

FALL 1995 VOLUME 17 NUMBER 3

Five Small Steps Will Make a Big Difference Toward Improving Children's Health in Canada!

For many Canadian children, the path to becoming a healthy adult is difficult and full of obstacles.

Did you know that every year in Canada

- close to 3,000 babies die before their first birthday
- 22,000 babies are born weighing less than 2500 grams
- Injuries represent 40% of the deaths among preschoolers
- before the age of 18, one in four girls and one in eight boys are sexually abused.

The Canadian Institute of Child Health has been the only national organization solely dedicated to improving the health status of Canadian children and youth.

The Institute has successfully developed alth promotion and disease prevention programs to act before a child gets sick and health is compromised.

Five Steps Toward a Healthier Country

By the year 2000, CICH will take five extremely important steps toward improving children's health:

✓ **Prevention of Child Sexual Abuse**

Everyday, a number of children in Canada are robbed of their childhood, falling victim to the crime of child sexual abuse — the ultimate betrayal of trust. Before the age of 18, one in four girls and one in eight boys are tricked, bribed or forced into sexual activity by a teenager or adult. Studies show that children with disabilities are two to ten times more likely to be assaulted. Adolescents who have been sexually abused as a child have been found to be at greater risk of alcohol or drug abuse, juvenile prostitution, suicide attempts, eating disorders, becoming runaways, depression, and repeating the cycle as adults.

CICH's goal is to mobilize all communities in Canada to initiate a child sexual abuse prevention program. CICH has developed and piloted a community kit on preventing child sexual abuse. The kit is designed so that parents, day-care workers, educators, police, clergy, youth leaders, health care workers and other concerned adults can use it to initiate prevention activities. Our goal is to distribute this kit to all communities in Canada and ensure that it is used. The project will produce critical long-term benefits for everyone in society by:

- reducing incidence of child sexual abuse and its latent effects;
- increasing Canadians' understanding of child sexual abuse and its prevention;
- increasing involvement in prevention programs; and
- improving how adults listen to and respond appropriately to children;
- improving attitudes toward violence, sex-role stereotyping and sexuality.

✓ **Prevention of Low Birth Weight and Prematurity**

A low birth weight baby is one who weighs less than 2500 grams at birth. In 1990, there were 22,000 babies born in Canada who were low birth weight (LBW). In addition to consuming a tremendous volume of medical resources, these babies are at increased risk of death and more likely to develop serious health problems and disabilities throughout life. Low birth weight makes adults two to three times more likely to have a heart attack, develop high blood pressure or diabetes.

CICH has long recognized that prevention of LBW will be far more effective than treating its effects. Three years ago, CICH established a Coalition for the Prevention of Low Birth Weight and Prematurity to improve research and education on preventing LBW. Given the substantial size of the problem of LBW and the serious effects it has on a child's health, it is essential that the work of this coalition be strengthened.

CICH has convened a national secretariat for the Coalition on the Prevention of Low Birth Weight and Prematurity. The secretariat will support the role of the coalition and local organizations, provide the inspiration and motivation for increasing involvement in the coalition, and be responsible for developing educational resources and projects to improve community action. The resources will include fact sheets on LBW and information and resources for staging successful LBW prevention projects. In addition, CICH will provide a network for information sharing and support.

Thanks to CICH's New Supporters

Special thanks to CICH's most recent supporters: Corel for its donation of software; Eurotranslation for translation services; and Dr. Graham W. Chance, Mr. Claus Wirsig and Helene Berman for their generous contributions.

Help the Institute advance the health and well-being of Canada's children. Please contact CICH today.

Inside...

The long-term benefits of supporting the CICH LBW prevention program will result in:

- a reduced incidence of LBW;
- measurable changes in infant death rates and illness;
- reduced incidence of childhood disabilities, including learning disabilities, emotional illness and chronic illness;
- increased awareness of all Canadians of the issues and the potential for preventing LBW;
- reduced burden on the health care, rehabilitation care and social service systems; and
- long-term improvements in adult health.

✓Injury Prevention

The innate inquisitive nature of small children has resulted in injuries being the leading cause of death and illness of Canadian children after one year of age. CICH's goal is to reduce the number and the severity of injuries to toddlers and preschoolers by making both caregivers and parents aware of common safety hazards and the steps they can take to reduce hazards.

CICH is developing an education program aimed at preschool teachers, caregivers and day-care workers which will help to identify and eliminate potential hazards within the child care setting and encourage child care workers to incorporate safety tips as part of their daily interaction with parents. CICH will also develop a resource kit for distribution to all day-care centres, preschools and out-of-home child care centres. The kit will include information on childhood injuries and make available to caregivers resource material on ideas for program implementation, a guide to resources in the community, and suggested activities to undertake with parents and children.

A second program will be aimed at current and prospective parents of preschool children. It will instruct parents on injury prevention activities within the home. A kit will be developed for parents on potential hazards within the home. This kit can also be used by community-based groups or community service organizations (e.g., prenatal courses, post partum classes, first-aid courses, babysitting courses).

The long-term benefits include:

- reduced death due to suffocation, burns, poisoning, motor vehicle accidents, drowning and falls;
- safer homes and child care settings;
- reduced disabilities;
- reduced hospitalization and use of the system of care; and
- fewer visits to hospital Emergency Departments.

✓Monitoring Child Health

A timely and accurate picture of the state of children's health in Canada is essential for taking stock of their health problems, for assessing the progress which has been made, and for identifying what must be high on the national agenda for the period ahead. At present, CICH is the only national organization that comprehensively monitors the health status of children and youth in Canada. Through the publication of *The Health of Canada's Children: A CICH Profile* (editions 1 and 2), CICH has successfully alerted policy makers at all levels to issues affecting children's health in Canada. Unfortunately, resources are not available to establish a system that will ensure ongoing monitoring and timely reporting on children's health needs.

CICH's goal is to continue its leadership role in monitoring children's health by publishing "The Health of Canada's Children: A CICH Profile, 3rd Edition" in 1997. The continued publication of the CICH Profile is essential as it provides a national benchmark for assessing the health status of Canadian children and youth.

✓A Voice for Children and Youth

Children do not determine the circumstances of their birth or rearing, nor can they be responsible for the environments in which they live. Children are, however, the primary victims of the current pressures on family time and finances. Children's needs are greater now than they have been for the last 40 years and must be considered as important as the resolution of the country's fiscal deficit. Children's needs must be given a special place on our national agenda.

CICH's goal is to make clear to the public, government and corporate sectors that children must be the country's top priority. CICH will undertake a multi-pronged awareness campaign promoting children as a vital priority for Canada.

Long-term benefits include:

- increased awareness at all levels of children's health needs;
- improved allocation of resources to prevent the major problems facing children's health;
- improved health status of children, youth and adults;
- decreased reliance on the health and social service systems; and
- a healthier and more productive work force in the future.

Every Small Step Counts...Every Penny Counts!

CICH has undertaken a major campaign to raise $100,000 a year for the next five years. These funds will come from three very important sources: individuals, corporations and foundations. These five key initiatives cannot be achieved without your support. As a grown child, friend, neighbour, brother, sister, aunt, uncle, grandparent or parent, we can all take pride and benefit from ensuring that children and youth live healthy, happy lives! Your donation, big or small, will help ensure that Canadian children are born healthy and stay healthy into adulthood.

Be a part of the movement and support CICH and Canada's future!

Association Teamwork Way of the Future

CICH and several other associations met with Lloyd Axworthy, Minister of Human Resources Development Canada, to discuss the impact the last federal budget will have on children and families. The meeting stemmed from discussions between the YMCA and other non-profit/voluntary associations about common concerns relating to more stringent federal government funding.

Although it is obvious that significant changes are ahead in how the government supports and funds services and programs, it remains to be seen how the budget will affect individual operations. At the meeting, strategies were explored about how the non-profit/voluntary sector and the government can work together more constructively to provide viable, effective services for children, youth, the disadvantaged and to strengthen community capacity building.

The Canadian Institute of Child Health (CICH) is a national multidisciplinary, non-profit organization dedicated to promote the health and well-being of Canadian children through consultation, collaboration, research and advocacy by building alliances and coalitions, and by publishing written and visual resources on health promotion and disease prevention relevant to child and family health in Canada.

Child Health, our quarterly newsletter, will keep you up to date on current issues and resources.

For membership/subscriptions, or for more information, contact CICH, 885 Meadowlands Drive East, Suite 512, Ottawa, ON K2C 3N2, Tel: (613) 224-4144, Fax: (613) 224-4145.

CICH Annual Membership

Why Belong?

- Membership to *Child Health*, a bilingual, quarterly newsletter
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- Opportunities to participate on national committees

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INTERNATIONAL PLANNED PARENTHOOD FEDERATION

REGENT'S COLLEGE, INNER CIRCLE, REGENT'S PARK, LONDON NW1 4NS
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JANUARY 1995

SEXUAL HEALTH AND COMMUNITY DEVELOPMENT
A NEW APPROACH FOR FAMILY PLANNING ASSOCIATIONS

Just under a year ago, six family planning associations (FPAs) in Africa, Asia and the Caribbean, embarked on a completely new, international project aimed at improving sexual health at the community level. Under the general direction of the International Planned Parenthood Federation's Sexual Health Project, these six FPAs are undergoing a subtle but profound change: most particularly in the way their staff and volunteers are learning to better understand the real needs and concerns of people in the communities they serve.

IPPF's member associations in Burkina Faso, Dominican Republic, Gambia, Ghana, India and Tanzania are exploring sexual health in a new way: one which embraces traditional programme areas (such as reproductive health, family planning, sexually transmitted disease control and HIV/AIDS) but also includes an area largely ignored by current programmes — community discussion of concerns around sexuality and human relations. Such discussion is a fundamental and vital starting point for behavioural and social change. Family planning workers are encouraging groups to ***articulate*** their concerns and to ***identify*** the issues which lie behind these: issues that relate inevitably to the social, political and economic environments in which people live, as much as to the services provided.

Implications of this work are far-reaching. IPPF's Sexual Health Project is creating the opportunity for people in marginalized villages and neighbourhoods to take independent, community action to change their lives for the better, as well as to review the very nature and development of FPA service delivery.

The attached international primary health care newsletter *Health Action* provides an overview of the significance of sexual health in the context of community development, and of the IPPF Sexual Health Project in particular.

For further information, and a copy of the paper *Participatory Operations Research and Sexual Health,* write to Sexual Health Project, at the address above.

Volume 29 Number 1 February 1995 *ISSN 0019-0357*
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IPPF *Medical Bulletin*

IMAP Statement on infertility

The statement below was revised by the IPPF International Medical Advisory Panel (IMAP) in February 1995.

Introduction

"The reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." (International Conference on Population and Development (ICPD) Cairo 1994.)

These concepts include concern for individuals and couples who are unable to have children when they desire them. Impaired fertility, variously described as infertility or sub-fertility, may be due to a relative or absolute inability to conceive, or to repeated pregnancy wastage. It affects both men and women in approximately equal proportions, causing considerable personal suffering and disruption of family life. The best strategy for dealing with the problem of infertility is its prevention. Although some cases of impaired fertility can be corrected by simple measures, other cases require complicated diagnostic procedures and treatment.

An empathic approach to individuals and couples who have infertility problems is required. This includes an appreciation of cultural and social customs, the individual's perception of sexuality, an understanding of the reproductive function and an awareness of the aetiology and prevalence of infertility in the community.

Prevalence and aetiology

FPAs should be aware of the prevalence and major causes of infertility in their areas. Although data on the prevalence of infertility are not very accurate and vary from region to region, it is estimated that 8–10% of couples experience some form of infertility problem during their reproductive lives.

Infertility can be due to male factors and female factors or a combination of these. The causes of male infertility may be classified as: abnormal spermatogenesis; disorders of secretory function of accessory organs; obstruction of the genital tract; and abnormal sperm function. The causes of female infertility are: ovulatory disorders; tubal occlusion; peritoneal factors, eg. pelvic inflammatory disease and endometriosis; cervical factors; and failure of implantation.

While the causes of infertility vary worldwide the most common causes are preventable. These include sexually transmitted diseases (STDs) and infections following childbirth or abortion. Tuberculosis may also cause infertility. Environmental and occupational health hazards may have an adverse effect on reproductive function and their effect on fertility should be studied further.

Contraceptive use and infertility

Barrier methods of contraception, especially the condom, protect against STDs and therefore against infertility. There is also sufficient evidence that oral contraceptives have a protective effect against PID.

Studies in different populations indicate that previous contraceptive use does not impair fertility. Previous IUD use has not been proven to cause infertility among women who are not at risk of STDs. The small risk of pelvic infection associated with IUD use can be reduced by proper selection of clients and the use of aseptic insertion techniques. Although progestagen-only injectables may cause delay in the return of fertility, this does not usually extend beyond 12 months after cessation of use.

Prevention

Since the major causes of infertility are preventable, FPAs should play an important role in reducing their incidence. The public need to be made aware through education programmes of factors which affect fertility. It should be widely publicized that infection caused by sexually transmitted diseases (STDs) is the most common cause of infertility. In addition, the contribution of infection caused by poor obstetric care and unsafe abortion should be stressed.

The FPA's role could be fulfilled by promoting programmes such as:

- the control of sexually transmitted diseases, including the use of STD diagnostic kits, the promotion of safe sex, and the use of condoms;
- better obstetric care at the primary health care level, including adequate training of traditional birth attendants;
- the prevention of unsafe abortion by improving access to effective contraception and safe abortion services;
- improving availability of reproductive health services (including information and education) for adolescents.

Services

The diagnosis and management of infertility is a complex process, requiring facilities and expertise not readily available within most FPAs' programmes. It is usually in the best interest of the couple that diagnostic procedures and management are performed in a centre where systematic and comprehensive services are available. FPAs should make an analysis of cost benefits and priorities when considering providing such services. Where these services cannot be provided, FPAs can play a useful role in helping infertile and sub-fertile couples by establishing a link with a well-equipped centre.

Clinical aspects

Comprehensive infertility treatment seeks to maximize the chance of pregnancy by optimizing all conditions for successful reproduction. Counselling, reassurance and timing of intercourse can achieve good results. Ovulation disorders usually respond to medical induction in more than 80% of cases. However, tubal damage requiring surgery cannot achieve these high success rates due to the underlying pathology. The treatment of male infertility with medication or surgery is largely unsuccessful. However, the use of donor semen insemination, when acceptable, may be a successful alternative.

New techniques of medically assisted conception have been developed to overcome the barriers preventing spermatozoa from encountering oocytes in infertile couples. These include artificial insemination; in vitro fertilization and embryo transfer; and techniques for gamete and zygote transfer. These services are expensive to establish, require proper case selection and should be restricted to tertiary referral centres.

There are many factors which affect the success of infertility treatment. This can be related to the cause of infertility, the characteristics of the infertile couple and the quality of the infertility treatment centre. FPAs should familiarize themselves with the success rates of local centres and convey this information to clients seeking assistance for infertility.

Psychological aspects

It is important to recognize the burden placed on couples seeking infertility treatment by many of the diagnostic and therapeutic procedures involved. They must be offered counselling and support because of the stress and anxiety caused by their persistent infertility and the complexity of the procedures involved. Health professionals should avoid a paternalistic attitude towards infertility clients, and make every effort to understand the needs and feelings of the couple. FPAs should also involve couples fully in decision-making about referral and treatment.

Where infertility treatment is unavailable or unsuccessful, FPAs should support and counsel individuals and couples to help them to come to terms with infertility. Advice should be given on the availability of adoption or fostering services, if that is a desirable alternative.

Social, legal and ethical issues

The development of medically assisted conception has brought new social, legal and ethical issues related to the management of infertility. FPAs should be fully cognizant of these issues, whenever they are in a position to refer clients for treatment or whenever they themselves establish a centre for such activities. These issues involve: respect for the dignity and integrity of the human being; protection of human genetic material so that it is not misused, or used inappropriately without the donors' consent; and the need for quality of care.

Statement developed by the International Medical Advisory Panel (IMAP) in October 1984 and amended by IMAP in April 1987 and February 1995.

IPPF reserves the right to amend this statement in the light of further developments in the field of infertility when sufficient scientific information becomes available.

Highlights of the meeting of the IPPF International Medical Advisory Panel, February 1995

At its meeting in London on 13–15 February, the IPPF International Medical Advisory Panel (IMAP) reviewed and updated six statements, including one on infertility which appears in this issue. The other statements referred to below will be published in future issues of the *IPPF Medical Bulletin*. Some of the highlights of the general discussions held during the meeting are outlined as follows:

- **Statements concerning hormonal methods of contraception**

The Panel decided to review and update IMAP statements concerning hormonal methods of contraception so that recommendations contained in a report of a WHO meeting on eligibility criteria for the use of hormonal methods and IUDs could be incorporated. The WHO meeting was a consensus-building meeting at which IPPF participated. The following statements were also updated in the light of recent clinical and epidemiological data: Steroidal Oral Contraception; Injectable Contraception; Norplant Subdermal Contraceptive Implant System; Contraception for Women over 35; and Contraception for Women with Medical Disorders. The IMAP statement on IUDs will be reviewed at a future meeting.

- **Use of progestagen-only contraceptive methods during breast feeding**

IMAP reviewed this topic because the Panel considers progestagen-only contraception to be an important option for any woman wishing to practise contraception. It is a particularly important method for women in the post-partum period who are breast feeding. The Panel reconfirmed its current position — that progestagen-only contraceptives (which include progestagen-only Pills (POPs), progestagen-only injectables (DMPA and NET-EN) and Norplant) do not interfere with lactation — and recommended their use from six weeks post-partum in breast-feeding women. IMAP endorsed a statement from Family Health International on 'Progestin-Only Pill Use and Pill Switching During Breast Feeding'. This is consistent with IMAP recommendations and emphasizes that breast-feeding women may switch to combined oral contraceptives at six months post-partum or when the infant is weaned, whichever is the earlier. IMAP particularly stressed the importance of including POPs in family planning programmes, especially for women who are breast feeding.

- **Administration schedule of NET-EN**

IMAP had received a request for clarification on the administration schedule of NET-EN. It has been generally recommended that the first three injections should be given at intervals of eight weeks and thereafter at intervals of eight or 12 weeks. The alternative between the two proposed intervals may be confusing for service providers if the criteria for deciding in every individual case is not given. Therefore, **IMAP recommended that the eight weeks interval should be maintained for the whole duration of NET-EN use** because higher pregnancy rates have been observed when it is given at 12-weekly intervals.

PRINTED IN ENGLAND BY STEPHEN AUSTIN AND SONS LTD, HERTFORD

THE ALLIANCE OF MIDWIVES, MATERNITY AND NEONATAL NURSES OF NEWFOUNDLAND AND LABRADOR

APPLICATION FOR MEMBERSHIP
1996

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I wish to be a member of the Alliance and I enclose a cheque for

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Membership for midwives is $20.00 (as this includes the Canadian Confederation of Midwives membership fee of $5.00 a midwife which the Alliance has to pay).
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Membership for those who are residing <u>outside of Canada</u> $30 (to cover the cost of the extra postage).

Signed: _____ Date: _____

Return to: Clare Bessell, (The Alliance Treasurer),
37 Smith Avenue, St. John's, Newfoundland A1C 5E8